In Your Language

Dear *Member*,

We know that it is important to communicate clearly so you can get the *health care services* you need.

In the United States, there are laws, such as the Civil Rights Act of 1964, which protects you if you do not speak English. If you cannot hear or are hard of hearing (hearing impaired) or *disabled*, aged or blind, you are also protected by the Americans with Disabilities Act (ADA) of 1990. The ADA is a law that protects people with *disabilities* from discrimination. The ADA makes sure that there is equal opportunity for persons with *disabilities* in employment, state and local government services.

The doctor's office, clinic or *hospital* cannot deny services because you do not speak English or are hearing impaired. You have the right to free *interpreter* services when getting health care or any related service through your health plan. An interpreter is a person who translates orally what is said in one language to another language. This allows persons of different languages to speak with each other and understand each other.

The meaning of italicized words are found in the "Glossary Section" at the end of this Member Handbook.

IMPORTANT NOTICE: YOUR SPOUSE AND CHILDREN ARE NOT ELIGIBLE FOR BENEFITS UNDER THIS PLAN. Newborns or legally adopted children after 31 days of birth are not eligible for Benefits under this plan. However, they may be eligible for other health care programs. The Community Health Plan (CHP) can help you find coverage for your dependents. Call the CHP Member Services at 1 (800) 475-5550 for more information.

The **Evidence of Coverage** is also called the Member Handbook. The Member Handbook tells you how to get health care. It also has the terms and conditions of your health *benefits* coverage. You should read the Member Handbook completely and carefully.

If you have special health needs, you should read the sections that apply to you.

This Member Handbook and the Summary of Benefits Section are only a summary of the **Community Health Plan** policies and rules. You must look at the contract to determine the exact terms and conditions of coverage. Call **Community Health Plan** if you have questions about covered services, specific provisions or if you would like to request a copy of the contract.

Community Health Plan
1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit #4
Alhambra, CA 91803-1323
Phone: Toll-Free 1 (800) 475-5550
Fax: 1 (626) 299-7258 or 7259

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WELCOME TO Community Health Plan

Thank you for choosing health care coverage with the Community Health Plan. Please review the information in this guidebook carefully. The information will help you use the Plan's medical services effectively.

Your medical care will be provided by qualified, health care professionals in one of our doctor offices, clinics or hospitals. Your Primary Care Provider will work with other doctors in all major specialties, pharmacists, nurses and other health professionals to assure that you receive the best health care.

If you have any questions or comments about the Community Health Plan or would like additional information about ***PASC – SEIU Homecare Workers Health Care Plan*** health care benefits, please contact a Plan Representative at the clinic/doctor office where you receive your medical care (refer to the Community Health Plan Provider Directory), or you may write or call us at:

Community Health Plan
Member Services Department
1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit # 4
Alhambra, CA 91803-1323
1 (800) 475-5550
TDD Service: 1 (626) 299-7265 & 7266

Along with this Member Handbook you should have received a *provider directory*, and a **Community Health Plan** identification (ID) card.

We will be glad to answer your questions and listen to your comments.

YOUR RIGHTS AND RESPONSIBILITIES

Member Bill of Rights

Member Rights **You have the right to:**
1. Have a confidential relationship with your doctor. This means that your health care will not be discussed without your permission.
2. Have access to your medical records and have them kept confidential.
3. Have an appointment with your doctor within a reasonable time and have your doctor listen and work with you to take care of your health care needs.
4. Dignified, courteous, and considerate care regardless of race, creed, sex, age, cultural, or ethnic background.
5. Be informed of all procedures, including appeals and *grievances* with **Community Health Plan**.
6. Receive information and to be spoken to in the language that you understand and are comfortable with.
7. Refuse medical treatment.
8. Receive preventive *health care services*.
9. Know and understand your medical problem and treatment plan.
10. Have a response to a request for service, including routine specialty referral *authorizations* within 5 working days. You can also have an urgent referral *authorization* request the same day, and an emergency referral *authorization* request immediately upon request.
11. A second opinion.
12. Know when your doctor is no longer contracted with your Health Plan.
13. You have the right to file a grievance with **Community Health Plan** if you do not receive your services in the language you requested.

Member Responsibilities **You are responsible for:**
1. Participating in your health care. This means taking care of problems before they become serious. You should always follow your doctor's instructions, take all your medications, and participate in health programs that keep you well.
2. Using the Emergency Room for real emergencies only. Your *PCP* will provide most of the medical care you need.
3. Being courteous and cooperative to people who provide you or your with *health care services*.
4. Making and keeping appointments for check-ups. You should always call your doctor's office when you need to cancel.
5. Participating in Satisfaction Surveys.
6. Helping Community Health Plan maintain accurate and current medical records by providing timely information regarding changes in address, and other health plan coverage.
7. Paying any Premiums, Co-payments and charges for Covered Services on time.
8. You are responsible for reporting Health Care Fraud. You can report it without giving us your name. Call **Community Health Plan** at toll free **1-800-475-5550.**

Confidentiality

You have the right to keep your medical records confidential. **You can request a copy of our confidentiality policy.** Just call **Community Health Plan**. Also, any results from genetic testing will not be disclosed. No one may tell others about the results of your genetic tests.

HOW TO USE COMMUNITY HEALTH PLAN

Your Identification (ID) Card

Your **Community Health Plan** ID card lets people know you are our *member*. Carry your **Community Health Plan** ID card with you at all times. Show your **Community Health Plan** ID card when you:

- Have a doctor's appointment,
- Go to the *hospital*,
- Pick up a *prescription*, or
- Get any other medical care.

Never let anyone use your **Community Health Plan** ID card. Letting someone else use your **Community Health Plan** ID Card with your knowledge is fraud.

Primary Care Physician (PCP)

A *primary care physician (PCP)* is your personal doctor. A (PCP) will be assigned to you upon enrollment based on:

- The language you speak.
- How far you live from the PCP's office.
- Specialty care most appropriate for a *member's* age.

He/she will make sure that you get all the health care you need. He/she will refer you to a specialist when needed. As your *PCP* learns more about you and your health, he/she can provide you with better quality care.

How to Change Your Primary Care Physician (PCP)

Choose a *PCP*
To change PCP's call **Community Health Plan.**
You may change your PCP for any reason if you are not happy with the assignment. It is important that you visit your PCP regularly.

You can choose any *PCP* from the **Community Health Plan** *provider directory*.

Points to remember when choosing a *PCP*.

- When you choose a *PCP* you are also choosing the specialists*, hospitals* and other health care *providers* within their *network*.
- Your *PCP* chooses from the *providers* within their *network* when referring you to needed services.
- You will be informed within 30 days if your *PCP* stops working with **Community Health Plan.**

How to Get Health Care Services

How to Get Routine Care

Regular health check-ups help you stay healthy. Routine care is when you go to your *PCP* for a regular health check-up, even when you are not sick. To get a regular health check-up you need to call and make an appointment.

Examples of routine care include:

- Initial Health Assessment (first health check-up)

You need to make an appointment for your first health check-up as soon as possible if you are a new *member* of **Community Health Plan**. This check-up will help you and your *PCP* know each other better. It will help him/her provide you with better care.

Scheduling a Doctor's Appointment

Call your doctor's office.

Your *PCP's* phone number can be found on your ID card or in the *provider directory*. You should have received a copy of the *provider directory* with this Member Handbook. Call **Community Health Plan** if you need another copy.

Canceling or Rescheduling a Doctor's Appointment

Please call and let your doctor know right away if you need to cancel an appointment. By canceling your appointment you allow someone else to be seen by the doctor. If you miss your appointment, call your doctor right away to reschedule.

How to See a Specialist

Specialists are doctors who take care of special health problems. Specialists are doctors with training, knowledge, and practice in one area of medicine. For example, a cardiologist is a heart specialist and has years of special training to deal with heart problems.

If your *PCP* thinks it is *medically necessary* for you to see a specialist, your *PCP* will refer you.

How To See a Mental Health Specialist

Specialized mental health services are provided through Los Angeles County Department of Mental Health (LACDMH). You may receive services from LACDMH with or without a referral from your PCP. LACDMH may be reached toll-free at 1-800-854-7771. Your PCP may treat some mental health conditions.

Prior Authorizations and Referrals

Your *PCP* must approve all *health care services* before you receive them. This is called *prior authorization*. A referral is when you request *health care services* that your *PCP* does not normally provide. Some services do not require a referral. Emergency services do not require a prior authorization. Go to the "Summary of Benefits Section" for a list of services.

There are different types of referral requests:

- Routine or Regular
- Urgent
- Emergency

After you receive a referral request, it will be reviewed and responded to as follows:

- Routine – 7 days
- Urgent – 24 to 48 hours
- Emergency – same day

Please call **Community Health Plan** if you have not received a response within the above time frames.

All *health care services* are reviewed, approved or denied according to *medical necessity*. If you would like a copy of the policies and procedures **Community Health Plan** uses to decide if a service is *medically necessary*, call **Community Health Plan.**

How to Get a Second Opinion

A second opinion is a visit with another qualified health care professional when:

- You question a *diagnosis*,
- You do not agree with your *PCP's* treatment plan, or

- You would like to make sure your treatment plan is right.

The second opinion must be from an *appropriately qualified health care professional* in your *network*. If there is no qualified health care professional who meets the standards, your doctor may authorize the referral to an out-of-plan provider. You have the right to ask for and to get a second opinion.
If your second opinion is approved either inside or outside of your provider network your travel to the doctor will be taken into account. If your second opinion request is approved you may be charged a co-pay for similar referrals.

What do you need to do?

Step 1: Talk to your *PCP* or **Community Health Plan** and let him/her know that you would like to see another doctor of your choice and the reason why.

Step 2: Your *PCP* or **Community Health Plan** will refer you to an *appropriately qualified health care professional* .

Step 3: Call the second opinion qualified health care professional to make an appointment.

If you do not agree with the second opinion, you may file a *grievance* with **Community Health Plan**. Go to the "Grievances/ Complaints and Appeals Section" for more information.

How to Get a Standing Referral

You may receive a "standing referral" to a specialist if your PCP and the specialist decides that you have a condition or disease that requires specialized medical care over a prolonged period of time.

A standing referral needs *authorization*. Once you have a standing referral, you will not need *authorization* for each visit with the specialist or *appropriately qualified health care professional*. A standing referral is made to a specialist or *appropriately qualified health care professional* who is in your *network* or who is with a contracted specialty care center. For a list of *appropriately qualified health care professionals,* call **Community Health Plan**.

Your specialist or *appropriately qualified health care professional* will develop a treatment plan for you. The treatment plan will show how often you need to go to the doctor. Once the treatment plan is approved, the specialist or *appropriately qualified health care professional* will be your coordinator of care, according to the treatment plan.

How to Keep Seeing Your Doctor if Your Doctor Has Left the Plan

You will be informed if your doctor stops working with **Community Health Plan**. You can ask to keep seeing your doctor, if your doctor is no longer working with **Community Health Plan** and has been treating you for any of the following conditions:

- *Acute* condition
- Serious *chronic* (long-term) condition
- High-risk pregnancy, or for a pregnancy that has reached the second or third trimester.

You have up to 90 days or longer to choose another doctor for a safe transfer. Please call **Community Health Plan** if you have any questions.

How to Get Urgent Care

Urgent care is what you need when a condition, illness or injury is not life-threatening, but needs medical care right away. Many of **Community Health Plan's** doctors have urgent care hours in the evening and on weekends.

For urgent care, follow these steps:

Step 1: Call your *PCP*.

Another doctor may answer your call if your *PCP* is not available. A doctor is available by phone 24 hours a day, 7 days a week.

Step 2: Tell the person who answers the phone that you are a **Community Health Plan** *member*.

Step 3: Ask to speak to your *PCP* or the doctor on-call. Tell the doctor what has happened and follow his/her instructions.

Call **Community Health Plan** if you cannot contact your *PCP***.**

How to Get *Emergency Care*

***Emergency Medical Condition* is** a medical condition manifested by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health or unborn child in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any body organ or part. This includes psychiatric disturbances and symptoms of substance abuse.

Emergency Services and Care

Definition

Emergency Services and Care is twenty-four hour medical care that includes medical screening, examination, and evaluation by a physician, or, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and if it does, the care, treatment, and surgery by a physician that is necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

Community Health Plan covers all emergency medical conditions. at all places. *Emergency care* is what you need when you have acute symptoms of sufficient severity (including severe pain) that would significantly impair your health if not treated right away. Emergency services also include ambulance and *mental health* services for emergency cases.

Examples of emergencies include:

- Hard to breathe
- Seizures (convulsions)
- Lots of bleeding
- Unconsciousness/blackouts (will not wake up)
- Severe pain (including chest pain)
- Swallowing of poison or medicine overdose
- Broken bones

What to do in an emergency.
Call 911, or go to the nearest emergency room.

After you receive emergency care.
Step 1: Follow the instructions of the emergency room doctor.

Step 2: Call your *PCP* to make an appointment for follow-up care.

Unsure if you need emergency care?
Step 1: Call your *PCP* or **Community Health Plan**.

Step 2: Tell them about your condition and follow their instructions.

Do Not Use The Emergency Room For Routine Health Care Services.

How to Get Emergency Transportation

Definition

Emergency Services include medical screening, examination, evaluation and treatment for an emergency medical condition or active labor. Emergency services also include care for an emergency psychiatric condition.

Emergency transportation is available to you when you have an emergency medical condition. If you are not sure if you need emergency transportation, you may call your PCP and follow her/his advice or you may call the Plan's 24-hours After-Hours Medical Advice Service at 1 (800) 832-MEDI (1-800-832-6334).

Ambulances for medical emergencies are paid for by **Community Health Plan**. You should seek emergency services and/or "911" services (including ambulance transportation) if you believe that a medical condition is an emergency medical condition in accordance with Community Health Plan's definition of emergency services.

How to Get Non-Emergency Transportation

Many **Community Health Plan** doctors offer non-emergency transportation. This may include litter (stretcher) and wheelchair van services to and from appointments. Please call the doctor's office or **Community Health Plan** if you want help with transportation for your medical visits.

How to Get Your Prescriptions Filled

Community Health Plan works with *pharmacies* in many neighborhoods. You must get your prescribed drugs (s) from a *pharmacy* in **Community Health Plan's** *network*. A list of **Community Health Plan's** *pharmacies* can be found in your *provider directory,* which is included in your welcome packet.

To get prescriptions filled:

Step 1: Find a *pharmacy* that accepts **Community Health Plan**.

Step 2: Bring and show your *prescription* and your **Community Health Plan ID Card** to the pharmacist.

What drugs are covered

Community Health Plan uses a list of approved drugs called a formulary. Your doctor normally prescribes drugs from the formulary. The formulary also identifies if a drug on the list is preferred over other listed drugs. **Drugs in the formulary are reviewed by a committee made up of health plan physicians and pharmacists, which meet monthly. Drugs are selected for this list based on how effective they are in treating a condition and how safe the medication is when compared to other available medications.**

Authorization for an off-label use or an FDA approved formulary medication, prescribed by a participating physician for a life-threatening or chronic and seriously debilitating condition, will be approved if your provider provides documentation supporting medical necessity, safety and efficacy for the intended use. Drugs listed on the Drug Formulary do not guarantee that they will be prescribed by your provider. However, authorization will be provided for a non-formulary medication if your doctor demonstrates that no formulary alternative exists and the medication is necessary due to either one of the following conditions:

- Lack of formulary alternative
- Failure to respond to appropriate formulary alternatives
- Documented allergy or adverse reaction to formulary alternative
- Special patient needs requiring a non-formulary medication

The Community Health Plan allows you to get the following drugs or supplies when prescribed by your doctor and *medically necessary*:

- *Prescription drugs* or supplies listed in the formulary.
- *Maintenance Supply of Generic Drugs for the treatment of chronic conditions may be supplied by our network of contracted pharmacies: 90 day supply. Brand name drugs are not a covered benefit for maintenance medications.*
- *Our network of contracted pharmacies may supply maintenance Supply Generic drugs for the treatment of chronic conditions: 90 day supply.*
- Diabetic supplies:

    1. Blood glucose monitors and blood glucose testing strips
    2. Blood glucose monitors designed to assist the visually impaired
    3. Insulin pumps and all related necessary supplies
    4. Ketone urine testing strips
    5. Lancets and lancet puncture devices
    6. Pen delivery systems for the administration of insulin

7. Podiatric devices to prevent or treat diabetes-related complications
8. Insulin syringes
9. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin

- Food and Drug Administration (FDA) approved contraceptive devices (including oral contraceptives and diaphragms).

Drugs not on the formulary
Sometimes, your doctor may need to prescribe a drug that is not on the formulary. Your doctor and/or pharmacist may call to get *authorization* from **Community Health Plan.**

To decide if the non-formulary drug will be covered, **Community Health Plan** may ask your doctor and/or pharmacist for more information. **Community Health Plan** will reply to your doctor and/or pharmacist within 24 hours after receiving all requested medical information.

Your doctor or pharmacist will let you know if the drug is approved. After approval you can get the drug at a *pharmacy* in your *network*. If the drug is not approved, you have the right to appeal the decision. Go to the "Grievances/Complaints and Appeals Section" for more information.

PAYMENT RESPONSIBILITIES

Prepayment Fees

Your employer is responsible for payment to the Community Health Plan of the periodic monthly charges **(Prepayment Fees)** for your coverage. Your monthly premium, which is your share of Prepayment Fees, will be deducted from your County pay through payroll deduction. Your employer will provide you with at least 30 day notice should your share of the Prepayment Fee be increased to cover taxes or licensing fees imposed on the Plan by a governmental entity. You will be notified by your employer of your share of the charges, if any. You are also subject to the Co-payments specified in this Member Handbook. Your maximum co-payment in any calendar year is $1,000.

The monthly premium schedule is as follows:

Enrollees	Gross Monthly Premium
Employee Only	$1.00

Subscriber Liabilities

1. By statute and contract with providers, you will not be held liable for payment of Plan-referred services to any provider contracted with the Plan in the event that the Community Health Plan fails to pay the provider.

2. You are responsible for your share of monthly premiums and co-payments, if any.

3. Co-payments for Covered Services provided to you are to be paid at the time services are rendered or within 30 days after you receive notice from the Community Health Plan.

4. The Community Health Plan will reimburse non-Plan providers for authorized services and emergency care only. If non-authorized health care services are obtained on a non-emergent basis from a provider not affiliated with your Primary Care Provider, you may be responsible for payment of the entire bill.

5. The contract provider is to accept the capitation payment, which will constitute payment in full for health care services rendered under the provider's contract with CHP.

6. CHP does not delegate its lien rights to contract providers.

HEALTH PLAN BENEFITS

Your *PCP* must arrange and *authorize* all your care before you receive services. All *health care services* are reviewed, approved or denied according to *medical necessity*.

There are some services your *PCP* does not need to arrange and *authorize*. These services include:

- Confidential HIV testing
- Emergency services
- *Family planning services*
- *Members* who receive certain Obstetrical/Gynecological (OB/GYN) services (includes pregnancy-related services). Just call an OB/GYN doctor who is in the same *network* as your *PCP* to make an appointment. Go to the "OB/GYN Section" for more information.
- Native American Indian *members* who receive health care from Indian Health Centers or a Native American Health Clinic.
- Sexually Transmitted Disease (STD) services
- Women, Infant and Children (WIC) services

Services
The services listed below are subject to all terms, conditions, limits, and exclusions described in the Member Handbook. This is not a complete list.

Alcohol/Drug Abuse
Crisis services are covered. Call **Community Health Plan** for more information or for a referral**.**

Cancer *Clinical Trials*

- **Cancer *Clinical Trials* –** If you have cancer, you may be able to be part of a cancer *clinical trial* that meets certain requirements, when referred by your **Community Health Plan** PCP or treating provider. The cancer *clinical trial* must be for a *curative* reason, and approved by one of the following:

  1. National Institute of Health (NIH)
  2. Food and Drug Administration (FDA)
  3. U.S. Department of Defense
  4. U.S. Veteran's Administration

If you are part of an approved cancer *clinical trial*, most common services will be covered.

Cervical Cancer Screening Test

- **Cervical Cancer Screening Test –** If you are referred by your Primary Care Physician (PCP) or treating provider, you may get any other Cervical Cancer Screening test that is approved by the Food and Drug Administration (FDA), in addition to the usual annual Pap Smear Test.

Confidential HIV Testing

You do not need prior *authorization* from your *PCP* for confidential HIV testing. A list of sensitive services is available. Please call **Community Health Plan** to request a copy. You can get confidential HIV testing from the following:

- Los Angeles County Department of Health Services
- *Family planning services providers*
- *PCP*
- Prenatal clinics

Diabetic Services

The following services are covered for diabetics when *medically necessary*:

- Blood glucose monitors and blood glucose testing strips
- *Blood glucose monitors designed to assist the visually impaired*
- Insulin pumps and all related necessary supplies
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Podiatric devices to prevent or treat diabetes-related complications
- Insulin syringes
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- Prescriptive medications for treatment of diabetes
- Glucagon
- Training and education for self-management
- Family education for self-management

Doctor Office Visits

All visits, exams, treatments and shots are provided by your *PCP*.

Drugs /Medications

Prescription drugs on the **Community Health Plan** formulary are covered. Go to the "How To Get Your Prescriptions Filled Section" for more information.

Durable Medical Equipment (DME)
DME is medical equipment that is used repeatedly by a person who is ill or injured. Examples include:

- Apnea monitors
- Blood glucose monitors
- Insulin pumps and related necessary supplies
- Nebulizer machines
- *Orthotics*
- Ostomy bags
- Oxygen and oxygen equipment
- *Prosthesis*
- Pulmo-Aides and related supplies
- Spacer devices for metered dose inhalers
- Tubing and related supplies
- Urinary catheters and related supplies
- Podiatric devices to prevent or treat diabetes-related complications
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin

Medically necessary DME is provided when ordered by your *PCP*.

Emergency Services
Emergency care is what you need when you have a condition, illness, or injury that is life-threatening or would significantly impair your health if not treated right away. This includes emergency transportation (ambulance).

Emergency care is covered anytime and anywhere.

Family Planning
You may receive *family planning services* and FDA approved contraceptives from any health care *provider* licensed to provide these services. Family planning *providers* include, but are not limited to:

- Clinics
- Nurses/midwifes
- OB/GYN services
- *PCPs*
- Planned Parenthood locations

Family planning services also include counseling and surgical procedures for the termination of pregnancy (abortion). You may need *authorization* for these services. Please call **Community Health Plan**.

You have the right to receive *family planning services* and choose a doctor or clinic not with **Community Health Plan.** You do not need *authorization* from your *PCP*. A list of family planning clinics is available. Please call **Community Health Plan** to ask for a copy.

Some *hospitals* and other *providers* may not provide one or more of the following services that may be covered under your plan contract and that you might need:

- ***Family planning services*;**
- Contraceptive services, including emergency contraceptives;
- Sterilization, including tubal ligation at the time of labor and delivery; or
- Abortion.

If you want more information, call your doctor, *medical group*, independent practice association (IPA), or clinic. You can also call Community Health Plan to ensure that you can obtain the *health care services* that you need.
The *State Department of Health Services (SDHS)* Office of Family Planning can also answer any questions or give you a referral for *family planning services*. You may reach them at 1-800-942-1054.

Health Education
Health education services:

- Promote healthy living
- Prevent diseases
- Help manage *chronic* diseases (such as asthma, diabetes and heart disease)

You can learn about health education services through:

- Classes
- Counseling
- Support groups

Diabetic self-management education programs are available. Go to Diabetic Services found in this "Summary of Benefits Section."

Ask your *PCP* for health education materials and classes. You can also call **Community Health Plan**.

Home Health
Medically necessary home health services are provided when ordered by your *PCP*.

Hospice Care
Medically necessary hospice care is provided when ordered by your *PCP*.

Hospital Care
Medically necessary hospital care is provided and includes, but is not limited to:

- *Inpatient* services
- Intensive care
- *Outpatient* services

Interpreter Services
An interpreter is a person who translates orally what is said in one language to another language. This allows persons of different languages to speak with each other and understand each other.

Services in your language are available 24 hours a day, 7 days a week. Call **Community Health Plan** or your *PCP***.**

Lab Services
These services (such as blood work, urine tests, and throat cultures) will be provided when ordered by your doctor, at a *network or out-of-network offices and facilities for emergency services and/or out-of-area urgent services:*

- Doctor's office
- *Hospital*
- Laboratory

Mastectomy
Mastectomy is a surgery to remove a breast, due to cancer. After a mastectomy **Community Health Plan** covers *prostheses* and reconstructive surgery. Go to Reconstructive Surgery found in this "Summary of Benefits Section."

As *medically necessary* you and your doctor can decide how long you need to stay in the *hospital* after the surgery.

Maternity Care
Maternity care includes:

- Regular doctor visits during your pregnancy (prenatal)
- *Diagnostic* and genetic testing
- Nutrition counseling
- Labor and delivery
- Health care 6 weeks after delivery (postpartum)

Call your doctor right away if you think you are pregnant. It is important to receive care right away and during your pregnancy.

You can choose your maternity care doctor from a doctor in your *network*. Ask your *PCP* for more information. You can also call **Community Health Plan**. You have the right to stay in the *hospital* for at least 48 hours for a vaginal delivery. You have the right to stay in the *hospital* for at least 96 hours for a cesarean section.

After giving birth, you will receive breast-feeding education and special equipment, if needed. Ask your doctor, or call **Community Health Plan** if you have any questions**.**

Go to the "Women, Infants, and Children (WIC) Program Section" for information about nutrition and food stamps.

Mental Health Services
Outpatient and inpatient mental health services are covered benefits as follows:

- Inpatient and outpatient benefits for Serious Emotional Disturbances (SED) of children are unlimited.
- Inpatient and outpatient benefits for Severe Mental Illnesses are unlimited for members of all ages.
- Outpatient Mental Health Services (non – SED/SMI) visits are limited to 20 visits per year.
- Inpatient Mental Health Services (non – SED/SMI) are limited to 30 days per benefit year for treatment of acute phase of mental health conditions during a certified confinement in a Plan hospital.

Military Disabilities
We will coordinate services with military connected disabilities for which facilities are reasonably available to members.

Newborn Care
Your new baby after 31 days of birth will not be covered by the **Community Health Plan**. To *enroll* your baby in *Medi-Cal and/or Healthy Families Program*, contact the DPSS toll-free at 1-877-481-1044.

A **Community Health Plan** doctor in your *network* should see your baby within the first 2 weeks of birth.

Newborn screenings for certain treatable genetic disorders are covered. These genetic disorders include:

- Phenylketonuria (PKU)
- Galactosemia
- Hypothyroidism
- Sickle cell disease
- Related hemoglobinopathies.

Babies with these conditions will be referred to California Children Services (CCS) for treatment. CCS treatment of PKU includes formulas and special food products. Go to the "Special Services for Children Section" for more information on CCS.

Nurse/Midwife and Nurse Practitioner
You may receive services from a nurse/midwife or certified nurse practitioner that works in your *PCP's network*. You do not need prior *authorization*. For more information ask your *PCP* or call **Community Health Plan.**

Obstetrics/Gynecologist (OB/GYN)
You do not need prior *authorization* from your *PCP* or **Community Health Plan** to see an OB/GYN doctor that works in your *network*. Please call **Community Health Plan** if you have any questions.

Prenatal Care
Go to Maternity Care found in this "Summary of Benefits Section."

Reconstructive Surgery
Reconstructive surgery repairs abnormal body parts, improves body function, or brings back a normal look. Reconstructive surgery is covered when *medically necessary.* Reconstructive surgery is provided, when requested by your treating *PCP* or surgeon and *authorized* by **Community Health Plan.**

Sexually Transmitted Disease (STD) Services
STD services include:

- Preventive care
- Screening
- Testing
- *Diagnosis*
- Counseling
- Treatment
- Follow-up

You have the right to receive STD services from any doctor or clinic**.** You do not need prior *authorization* from your *PCP*.

Skilled Nursing Facility
Medically necessary care in a *skilled nursing facility* is provided when ordered by your *PCP*. Go to the "Additional Disenrollments Section" for more information.

Therapy – Occupational, Physical and Speech
Medically necessary occupational, physical, and speech therapy are provided, when ordered by your treating physician and *authorized* by **Community Health Plan**. For treatment of acute conditions or the acute phase of chronic conditions if such conditions are in the judgment of the Plan Physician, subject to continuing significant improvement within a 2-month period commencing on the date the first such short-term rehab services were provided.

For information about vision care coverage call **Community Health Plan.**

X-ray Services
These services will be provided when ordered by your doctor at a *network or an out-of-network facility for emergency or out-of-area urgent services*:

- Doctor's office
- *Hospital*
- Laboratory

SUMMARY OF COVERED BENEFITS		
BENEFITS	**CO-PAYMENT SUBSCRIBER PAYS**	**LIMITATIONS**
OUTPATIENT SERVICES:		
• **Primary Care Visit Including:** Injectable Medications Allergy Testing	$5.00/Visit co-pay	
• **Preventive Health Services:** Periodic Health Examinations Cancer Screening Immunizations Vision/Hearing Screening Health Education Well-Child Care	$5.00/Visit co-pay No co-pay No co-pay No co-pay No co-pay No co-pay	Limited to first 31 days of life.
• **Prenatal and Postpartum Care**	No co-pay	
• **Family Planning:** Consultations Voluntary Termination of Pregnancy Tubal Ligation Vasectomy	No co-pay No co-pay No co-pay No co-pay	
• **Specialty Care Consultations/Visits**	$2.00/Visit co-pay	By Plan physician referral.
• **Diagnostic Laboratory, Radiology, ECG, EEG**	No co-pay	By Plan physician referral.
• **Therapeutic Radiology, Chemotherapy, Renal Dialysis**	No co-pay	By Plan physician referral.
• **Ambulatory Surgery**	No co-pay	By Plan physician referral.
• **Anesthesia**	No co-pay	By Plan physician referral.

SUMMARY OF COVERED BENEFITS		
BENEFITS	**CO-PAYMENT SUBSCRIBER PAYS**	**LIMITATIONS**
• **Blood, Blood Products And Their Administration**	No co-pay	By Plan physician referral.
• **Urgent Care Visits**	$5.00/Visit co-pay	
Emergency Department Visits: twenty-four hour emergency services and care, including medical screening, examination, evaluation and treatment for an emergency medical condition or active labor and psychiatric emergencies.	$35.00/Visit co-pay (waive if admitted to hospital).	
• **Physical, Occupational And Speech Therapy**	$5.00/Visit co-pay	Up to 30 visits per benefit year (combined PT, OT and speech therapy); no limits if medically necessary.
INPATIENT SERVICES:		
• **Room and board for all medically necessary services** • **Physician services in an acute hospital, skilled nursing facility, hospice or mental health facility** • **General and special nursing services** • **Operating and recovery rooms, other special care rooms as medically necessary** **Medical supplies**	All are no co-pay within Plan network or in documented emergency.	

SUMMARY OF COVERED BENEFITS		
BENEFITS	**CO-PAYMENT SUBSCRIBER PAYS**	**LIMITATIONS**
• **Pharmaceuticals** • **Anesthesia** • **Blood, blood products, and their administration** • **Obstetrical Care and delivery (including Cesarean section)** • **Newborn nursery care while mother is hospitalized and for the first 31 days of life** • **Diagnostic laboratory and radiology services**		
• **Respiratory therapy** • **Physical, occupational and speech therapy** • **Inpatient alcohol and substance abuse admissions for medically necessary detoxification** • **Dialysis** • **Coordinated discharge planning**		
OTHER SERVICES:		
• **Alcohol and Drug Abuse:** **Inpatient:** Covered only when medically necessary for detoxification	No co-pay	

SUMMARY OF COVERED BENEFITS		
BENEFITS	**CO-PAYMENT SUBSCRIBER PAYS**	**LIMITATIONS**
Outpatient: Evaluation, crisis intervention and treatment for conditions that are amenable to significant improvement through short-term therapy.	$5.00/Visit co-pay	Limit of 20 visits per benefit year.
Ambulance Air/Ground Ambulance if a Member reasonably believes an emergency exists that requires ambulance transport services.	No co-pay	
Dental Care Only when deemed medically necessary by Plan physician.	No co-pay	Does not cover routine dental services (e.g.; teeth cleaning, cosmetic).
Dialysis For acute renal failure and end stage renal disease	No co-pay	
Durable Medical Equipment: Medical equipment appropriate for use in the home, such as oxygen equipment	No co-pay	
Home Health Care Medically necessary skilled care	No co-pay	Does not cover custodial care.

SUMMARY OF COVERED BENEFITS		
BENEFITS	**CO-PAYMENT SUBSCRIBER PAYS**	**LIMITATIONS**
Hospice Two 90-day periods followed by an unlimited number of 60-day periods during entire lifetime when terminal illness certified by Plan physician	No co-pay	
Mental Health **Inpatient:**	No co-pay	Limited to 30 days per benefit year for treatment of acute phase of mental health conditions during a certified confinement in a participating hospital. Benefits for Serious Emotionally Disturbance (SED) of children and Severe Mental Illnesses (SMI) of members of all ages are not limited.
Outpatient: Primary Mental Health Visits Screening, evaluation and treatment.	$5.00/Visit co-pay	Limited to 20 visits per benefit year. SED of a child and SMI of members of all ages, visits are not limited.
Outpatient: Specialty Mental Health Visits	$2.00/Visit co-pay	

SUMMARY OF COVERED BENEFITS		
BENEFITS	**CO-PAYMENT SUBSCRIBER PAYS**	**LIMITATIONS**
Orthoses and Prostheses	No co-pay	
Prescription Drugs Up to 30 day supply of medically necessary formulary drugs when prescribed by Plan physician for short-term or acute illness. Medications to be provided by our network of contracted pharmacies.	$5.00 co-pay per medication	Up to 30-day supply of generic or brand drugs covered under the pharmacy plan. Drugs not covered and under the pharmacy plan require an authorization before they can be obtained as a covered benefit.
Maintenance drugs Supplied by our network of contracted pharmacies for treatment of chronic conditions: 90-day supply.	$5.00 co-pay pay per medication	Generic drugs only. Non-formulary generic drugs, which have been authorized by the pharmacy plan, may be obtained as a covered benefit. Brand drugs not a covered benefit.
Short Term Rehabilitative Services (Physical, Occupational, and Speech Therapy): **Inpatient:** **Outpatient**:	 No co-pay $5.00/Visit co-pay	As medically necessary.

SUMMARY OF COVERED BENEFITS		
BENEFITS	**CO-PAYMENT SUBSCRIBER PAYS**	**LIMITATIONS**
Skilled Nursing Care	No co-pay	No charge up to 100 days per calendar year in a licensed SNF when medically necessary.
Transplants Medically necessary organ and bone marrow transplants; medical and hospital expenses of a donor or a prospective donor; testing expenses and charges associated with procurement of donor organ.	No co-pay	

SUMMARY OF COVERAGE EXCLUSIONS

- Acupuncture
- Biofeedback
- Chiropractic Services
- Conception by Artificial Means
- Contraceptive/Devices that do not require a prescription (unless deemed medically necessary by Plan physician)
- Convenience Items (ie, TVs, telephones, etc.)
- Cosmetic Services (ie, surgery that is performed to alter or reshape normal structures of the body in order to improve appearance
- Custodial Care
- Routine Dental Services
- Experimental or Investigational Service/Supplies (Go to External Independent Review section for more information)
- Hearing Aids/Services
- Home/Vehicle Improvements
- Implants (except those deemed medically necessary)
- Infertility Treatments (except treatments for medical conditions of the reproductive system if deemed medically necessary by a Plan physician); treatments such as in vitro fertilization, gamete interfallopian transfer or other forms of induced fertilization, artificial insemination or services incident to or resulting from procedures for or the services of a surrogate mother are not covered services
- Long Term Care
- Obesity (treatment of except when deemed medically necessary by Plan physician)
- Orthopedic Devices/Other Supplies: except as provided under Orthotics and Prosthetics
- Over the Counter Drugs, Supplies, Devices
- Penile Implant Devices
- Physical Exams and Immunizations for Employment, Travel, etc. (unless the exam corresponds to the schedule of routine physical exams provided in preventive health services)
- Podiatry Services (other than diabetic foot care)
- Private Duty Nursing
- Sexual Reassignment Surgeries
- Sexual Dysfunction incident to non-physically related sexual dysfunction except as medically necessary

- Transportation (other than that provided under ambulance services)
- Vasectomy and Tubal Ligation Reversals
- Vision Care (not covered: eye glasses, contact lenses, routine eye exams except when provided as part of routine exam under preventive care)
- Workers' Compensation Benefits or other Liability

If you have questions about what is covered, please call **Community Health Plan**.

SPECIAL SERVICES

Special Services for Children

California Children Services (CCS)
CCS is open to persons under the age of 21 with a *disability*. If your child has a *chronic* medical illness, he/she may be *eligible* for services under CCS. Talk to your child's *PCP* about CCS.

Child Health and Disability Prevention (CHDP)
Your child may receive CHDP through your child's local school. You may call CHDP at (323) 890-7941, if you have any questions.

Special Services for Native American Indians

Native American Indian *members* have the right to get *health care services* at Indian Health Centers and Native American Health Clinics. You do not need to *disenroll* from **Community Health Plan** to get *health care services* from an Indian Health Center or Native American Health Clinic. Please call Indian Health Services at (916) 930-3927 for more information. You may visit the Indian Health Services website at www.ihs.gov for more information.

Women, Infants and Children (WIC) Program

The Women, Infants and Children (WIC) Supplemental Nutrition Program gives pregnant women, new mothers, and their babies nutrition information and food stamps. Ask your doctor or maternity nurse for more information about WIC. You may call WIC directly at 1-888-942-2229 or 1-888-WIC-Baby.

Federally Qualified Health Centers (FQHCs)

FQHCs are health centers that receive money from the federal government. FQHCs are located in areas that do not have a lot of *health care services*. As a *member* of **Community Health Plan,** you have the right to receive your health care at a FQHC that is contracted with **Community Health Plan**. Call **Community Health Plan** for the names and addresses of the FQHCs that contract with **Community Health Plan**.

GRIEVANCES/COMPLAINTS AND APPEALS

Grievances/Complaints

We want to know about any problems you may have in getting *health care services*. Have you had problems with any of the following?

- Your *medical group*
- Your doctor
- Your *hospital*
- **Community Health Plan**

Call the **Community Health Plan** *Member Services Department* if you have had problems. A Member Services Representative will make every effort to help you. If you are still not happy, you may use the **Community Health Plan** *grievance* process. This process lets us know that you are not satisfied. We want to hear your suggestions about how we can improve our services.

Step 1: When you have a *grievance* you may write, visit, or call **Community Health Plan** at:

Community Health Plan
Grievance Coordinator
1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit #4
Alhambra, CA 91803-1323
1 (800) 475-5550

You may fill out a *grievance* form at your doctor's office or call the **Community Health Plan** *Member Services Department* to have a form mailed to you.

Step 2: After you have filled out the form, return the form to **Community Health Plan.**

Step 3: After **Community Health Plan** has received your *grievance,* you will receive a letter within 5 days informing you that **Community Health Plan** has received your *grievance.* The letter will include a contact person who you may call for information.

Community Health Plan will review your *grievance* and work to resolve your problem. **Community Health Plan** will send you a letter of how the *grievance*

was resolved within 30 days from the day your *grievance* was received. The letter will include information on how to file an appeal with **Community Health Plan.**

1. If you are not satisfied with the resolution of the grievance, a written appeal may be submitted within 30 days of the Plan's decision to the Community Health Plan at the address below.

2. If you have a medical condition or other circumstances beyond your control that prevented you from complying with the 30 day time period you can submit your appeal to:

Community Health Plan
1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit #4
Alhambra, CA 91803-1323
Attention: Grievance Coordinator
1 (800) 475-5550

3. If you believe you need legal representation, contact your attorney or the Legal Aid Foundation at 1 (213) 487-3320 for advice.

A Plan Representative is available to assist you and provide information. If you have any questions regarding the grievance procedures, please call a Plan Representative at your primary care clinic/doctor office, or you may contact the Plan's Member Services Department at 1 (800) 475-5550.

Expedited Appeal (Urgent review of denied services)
In urgent cases where services were denied, you can request an expedited appeal. An expedited appeal is an urgent review of denied services. You will receive a call and/or a letter within 24 hours. The decision will be made by **Community Health Plan (first level of review)** within 3 days from the day your *grievance* was received.

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of your health

Ombudsman Office
You may also call the Ombudsman office of the *State Department of Health Services (SDHS)* for help with *grievances*. Call toll-free 1-888-452-8609.

Department of Managed Health Care (DMHC)

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. DMHC has a toll-free number **1-888-HMO-2219 (1-888-466-2219)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (**1-800-735-2929 (TTY)** or **1-888-877-5378 (TTY)** to contact DMHC. DMHC's Internet website (**http://www.hmohelp.ca.gov**) has complaint forms and instructions online. If you have a grievance against your health plan, you should first call **Community Health Plan** at 1 (800) 475-5550 and use the plan's grievance process before contacting DMHC. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call DMHC for assistance. The plan's grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Independent Medical Review of Grievances

The Independent Medical Review (IMR) is another appeal process that you may use if you believe a *health care service* has been improperly denied, changed or delayed by **Community Health Plan due to a finding by Community Health Plan that the service is not medically necessary**. You may still request a State Fair Hearing if you request an IMR. However, you will not be able to use the IMR process if you have requested a State Fair Hearing. Go to the "State Fair Hearing Section" for more information.

There are no fees for an IMR. You have the right to provide information when you file an IMR. A decision not to take part in the IMR process may cause you to forfeit certain legal rights to pursue legal action against the plan regarding the disputed health care services.

The IMR is filed with DMHC. You will receive information on how to file an IMR with your denial letter. You may reach DMHC at toll-free 1-888-HMO-2219 or 1-888-466-2219.

If you have filed an urgent grievance with Community health Plan that requires expedited review you will not be required to participate in the grievance process for more than 3 days.

When To File An IMR
You may be eligible for an IMR when:

- You have filed a *grievance* with **Community Health Plan** and the service is still denied, or the *grievance* remains unresolved after 30 days. You must first go through the **Community Health Plan** *grievance*/appeal process, before applying for an IMR. You have up to 6 months from the date of denial to file an IMR.
- The disputed *health care service* has been denied, changed or delayed by **Community Health Plan**, based in whole or in part on a decision that the *health care service* is not *medically necessary*.
- Your doctor has recommended a *health care service* because it is *medically necessary* or
- You have received urgent care or emergency services that a provider determined was necessary or
- You were seen by a network or an out-of-plan provider for the diagnosis or treatment of the medical condition for which you requested an independent medical review.

CHP will expedite access to a network doctor upon your request. The network doctor need not recommend disputed health care services as a condition for you to be eligible for an independent review.

All of these circumstances must be met to be eligible for IMR.

The dispute will be submitted to a DMHC medical specialist if it is *eligible* for an IMR. The specialist will make an independent decision of whether or not the care is *medically necessary*. You will receive a copy of the IMR decision from DMHC. If it is decided that the service is *medically necessary*, **Community Health Plan** will provide the *health care service*.

Non-Urgent Cases
For non-urgent cases, the IMR decision must be made within 30 days. The 30-day period starts when your application and all documents are received.

Urgent Cases
If your *grievance* is urgent and requires fast review, you may bring it to DMHC's attention right away. DMHC may waive the requirement that you follow the **Community Health Plan** *grievance* process.

For urgent cases the IMR decision must be made within 3 business days. Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb, or major bodily function
- Immediate and serious deterioration of your health

External Independent Review (EIR)

You can request an EIR when a medical service, drug or equipment is denied because it is *experimental or investigational in nature*. You may request in writing an EIR within 5 business days from the date of the denial. You may provide information to the EIR panel. The EIR panel will give you a written decision within 30 days from when your request was received. In urgent cases the EIR panel will give you a decision sooner.

You must meet all of the following to ask for an EIR:

- Have a very serious condition that is life-threatening or debilitating (for example, terminal cancer).
- Your doctor certifies that your treatment has not been effective.
- Your doctor requests in writing a drug, equipment, procedure, or other therapy that would work better for you.
- You have been denied a drug, equipment, procedure, or other therapy requested by your doctor.
- The use of a drug, equipment, procedure or other therapy is *experimental or investigational in nature* and has some scientific basis, as stated in California law.

For more information about the EIR process or to request an application form, please call **Community Health Plan**. If you need help writing the letter, please call **Community Health Plan**.

Arbitration

1. By enrolling in Community Health Plan, all Members agree to submit any and all disputes and claims (including malpractice claims) between the Member (or any person submitting a dispute or claim on behalf of the Member) and Community Health Plan, CHP's medical providers, and/or PASC – SEIU Homecare Workers Health Care Plan to binding neutral arbitration, rather than being heard before a court or jury. This means that

both Community Health Plan and the Member agree to forego rights to jury or court trial.

2. The arbitration costs will be shared equally by the Member and the parties (CHP, CHP's medical providers, and/or PASC – SEIU Homecare Workers Health Care Plan) involved with the Member's claim or dispute, unless the Member is unable to pay his/her share of the costs of the neutral arbitrator's fees.

3. Any arbitration proceeding will be held under the Commercial Rules of the American Arbitration Association. Copies of the current rules and details of the format and information required for an arbitration demand may be obtained by writing to the Community Health Plan Member Services Department at 1000 South Fremont Avenue, Building A-9 East, 2nd Floor, Unit #4, Alhambra, CA 91803-1323, or call Community Health Plan Member Services at 1 (800) 475-5550.

DISENROLLMENTS

Community Health Plan managed care coverage for *members* will end if any of the following has occurred:

- You are no longer employed by your Employer or you no longer meet all the requirements of your Employer.
- The end of the period for which premium payments were paid to Community Health Plan by the Employer.

Involuntary Disenrollments

Mandatory and voluntary *members* will be *involuntarily disenrolled* from **Community Health Plan** if any of the following has occurred:

- You allow someone else to use your **Community Health Plan** ID card
- You and your doctor are unable to work together (Community Health Plan will first try to establish you with another provider before disenrollment).
- You act in an abusive or violent way

If you are *disenrolled* from **Community Health Plan**, the employer will send you a letter that says when your coverage will end and why. You may file an appeal with **Community Health Plan**. Go to the "Grievances/Complaints and Appeals Section" for more information. You may also ask for a review from DMHC. Call **Community Health Plan** for more information.

Renewal Provision

If coverage is terminated by reason of termination as provided above, only the Employer may reinstate coverage.

Change in Benefits and Charges

Community Health Plan reserves the right to change the Benefits and charges of this group plan. The Employer or you will be given thirty-one (31) days' written notice for any change in Benefits and charges.

TERMINATION OF BENEFITS

Termination for Cause

You (as Subscriber) may be disenrolled from the Plan and Plan benefits terminated if the Subscriber or Member:

- Fails to pay any Co-payment(s), or fails to pay any other charges owed to the Plan after notices to pay has been sent to you.
- Persists in conduct which interferes with the effective provision of medical care, or
- Utilizes fraud or deception in the use of the Plan or a Plan provider's services or facilities, or knowingly permits such fraud or deception by another.
- No longer employed by his or her employer (A Subscriber or Member who works or lives within the statutory-defined distance of a Participating Provider site shall remain eligible for health care benefits)

Your Primary Care Provider will assist you in obtaining alternative coverage to ensure continuity of care if you become disenrolled due to non-payment of premiums or periodic charges while hospitalized or while receiving treatment for an ongoing medical condition. You will be notified in writing of the effective date of disenrollment. Benefits shall cease as of 12:00 a.m. midnight on such effective date.

If you believe that your membership was terminated or not renewed because of your health status or requirements for health care services, you may request a review by the Commissioner of the Department of Managed Health Care of such cancellation.

Plan Contract Cancellation

In the event that County terminates the Plan Contract with the Community Health Plan, all benefits provided by the Plan to Members shall cease as of 12:00 p.m. midnight of the effective date of Plan Contract termination, and the Plan shall have no further liability or responsibility for the care of Members who are not hospitalized at the time the Contract is terminated.

In the event that either the County or the Plan terminates the Plan Contract, any Member who is a registered bed patient in a hospital at the effective date of termination shall be held financially responsible for all services provided by the

Plan following the date of termination. In maternity cases under hospital inpatient care on the effective date of termination, the Plan shall continue obstetrical care only through hospital confinement and discharge. All other Plan benefits, other than those related to the hospitalization, will cease as of the effective date of the Plan contract termination. You will be held financially responsible for all services provided following such effective date of termination.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

Individual Continuation of Benefits

The Community Health Plan allows you (as Subscriber) to continue participation in the Plan by purchasing Continuation Coverage when certain events occur which would otherwise result in loss of Plan coverage.

How Continuation Coverage Works

You (as Subscriber) can extend participation in the Plan for up to 18 months if one of the following "Qualifying Events" occurs:

- Your employment terminates for any reason (including voluntary resignation or retirement) other than for gross misconduct, or
- Your hours are reduced resulting in ineligibility to participate in the Plan.

If you are determined to be disabled within 60 days of Continuation Coverage, you are entitled to a maximum coverage period of 29 months. The Plan must be notified prior to the end of the original 18-month continuation period. A Social Security disability termination notice must be submitted to the Plan's Membership Services Department within 60 days of determination of disability. Also, you must notify the Member Services Department within 30 days after the date it is determined that you are no longer disabled. Premium rates for Plan coverage during this period may be at a higher rate for the initial 18 months of such period.

Subscriber becomes eligible for coverage under Title XVIII of the Social Security Act (Medicare).

How to Obtain Continuation Coverage

To qualify for Continuation Coverage, the Plan must receive written notification from you within 60 days following the later of the date of the "Qualifying Event," the date you are given notice of the ability to continue coverage, or the date Plan coverage terminates. Disqualification to Continuation Coverage will occur if the Plan does not receive notification within the required 60-day period. The written notification may be by U.S. mail or by delivery. You will be contacted by the Plan within 14 days of notification. After receiving the Plan

information, you have 60 days to make a decision on whether to continue Plan coverage.

If the group service agreement between a plan and the County is terminated prior to the date continuation coverage would terminate, the Member may elect Continuation Coverage for the balance of the continuation period under a subsequent group benefit plan, if any. Read carefully the above referenced requirements for notification, and payment of premiums. Continuation coverage will terminate if Member fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new plan within 30 days of receiving notice of the termination of the prior group benefit plan.

Coverage Termination Prior to End of Continuation Period

Coverage will end before the end of the continuation period in any of the following circumstances:

- Payment of any required premiums or contribution is not received 30 days after it is due.
- You become covered by another group benefit plan.
- The Plan contract is canceled and County ceases to provide any group health plan to any employee.
- You (as Subscriber), become entitled to benefits under Title XVIII of the Social Security Act (Medicare).

Member Cost for Continuation Coverage

Under COBRA, you may be charged the full cost of the group plan coverage, plus a 2% administrative charge.

You must make payments for Continuation Coverage on a monthly basis. The first payment covers the period from the date coverage terminates until the date you elect Continuation Coverage, and is due within 45 days from the date you provide written notification to the Plan. Detailed information on dollar amounts will be provided on an individual basis after the Plan receives notification. The first premium payment must equal an amount sufficient to pay all required premiums and all premiums due. Failure to submit the correct premium amount within the 45-day period to the Plan (using a reliable means of delivery) will disqualify a qualified Member from Continuation Coverage.

Conversion Privilege

If you select Continuation Coverage, you may choose to convert to an individual coverage plan at any time during the last 180 day of coverage (see next section on Conversion Plan). If you do not choose Continuation Coverage, application for the Conversion Plan must be made within 30 days of termination of group coverage.

Conversion Plan

If your coverage ceases (not because of a reason stated in the Termination for Cause section of this Evidence of Coverage and Disclosure), you may purchase an individual medical coverage plan called the Community Health Plan Conversion Plan.

Conversion Plan coverage is available without medical review by applying within 30 days of the termination of group coverage. Conversion Plan coverage begins at the time group coverage ends, but only if the Member applies and pays the required premium within this 30 day period.

OTHER INFORMATION

If You Move

When you move it is important to call the following people:

- Call **Community Health Plan.** You will need to update your information (address and phone number). This allows **Community Health Plan** to send you your ID Card and important information about your health care *benefits*.

If You Get a Bill

Community Health Plan pays for all covered medical costs approved by your *PCP* or for an emergency. You should not receive a bill for any services covered by **Community Health Plan.** Please call **Community Health Plan** if you receive a bill for medical services.

If You Have Other Insurance

If you have any health insurance other than **Community Health Plan**, it is important to let us know. If you are covered by more than one group health plan or group insurance coverage, **Community Health Plan** will coordinate benefits with the other carrier. Please call **Community Health Plan** if you have any questions. We will send all bills to the correct place for payment.

How a Provider Gets Paid

Health care *providers* are paid in the following one way:

- Capitation - a flat rate paid each month per *member*

Please call **Community Health Plan** if you would like to know more about how your doctor is paid, or about financial incentives or bonuses.

THIRD PARTY LIABILITY & COORDINATION OF BENEFITS

Third Party Liability

If you are injured through the act or omission of another person (a "third party"), **Community Health Plan** shall, with respect to services required as a result of that injury, provide the Benefits under **Community Health Plan** only on the condition that the Member:

- The member Agrees in writing to immediately upon collection of damages, whether by action at law, settlement, or otherwise, to reimburse the Community Health Plan, the sum of the costs actually paid by the Community Health Plan, medical group, or independent practice association for health care services not provided on a capitated basis or

- For health care services provided on a capitated basis, to reimburse the Community Health Plan 80% of the usual and customary charges for the same services by medical providers that provide health care services on a noncapitated basis.

Coordination of Benefits

If you are covered by more than one group health plan or group insurance coverage, **Community Health Plan** will coordinate benefits with the other carrier. If another carrier is covering you under a group health plan is primary, then **Community Health Plan** or its **Community Health Plan** Providers will seek compensation from that carrier for benefits provided under **Community Health Plan** coverage. You will receive all of the Benefits to which you are entitled under this Plan, but no more than these benefits. This coordination of benefits will be done by **Community Health Plan** in accordance with the rules of the California Department of Managed Health Care.

When coordinating benefits, **Community Health Plan** determines the primary carrier as follow:

- If you are the Subscriber, then the coverage which you obtain through employment is primary.

Note: even if you have other coverage, benefits will only be covered under the **Community Health Plan** if provided by **Community Health Plan** providers and authorized in accordance with **Community Health Plan** rules.

Organ Donation

There is a need for organ donors in the United States. You can agree to donate your organs in the event of your death. The California Department of Motor Vehicles (DMV) will give you a donor card if you wish to become an organ or tissue donor. The DMV will also give you a donor sticker to place on your driver's license or I.D. card.

What is an Advance Directive?

An advance directive allows you to select a person to make your health care choices for you when you cannot make them yourself. For example, when you are in a coma. An advance directive must be signed when you are able to make your own decisions. Ask your *PCP* or call **Community Health Plan** for more information about advance directives.

Governing Law

Community Health Plan coverage is subject to the requirements of the California Knox-Keene Act, Chapter 2.2 of Division 2 of the California Health and Safety Code, and the regulations set forth at Subchapters 5.5 and 5.8 of Chapter 3 of Title 28 of the California Administrative Code. Any provision required to be in this benefit program by either the Knox-Keene Act or the regulations shall be binding on Community Health Plan even if it is not included in this Evidence of Coverage or the Group Service Agreement.

PARTICIPATING IN PUBLIC POLICY MEETINGS

Many of the **Community Health Plan** policies are decided by. Other policies are set by **Community Health Plan** and *members* like you.

Board of Governors Meetings

The Board of Governors decides policies for **Community Health Plan**.

Communicating Policy Changes

You will get information on all policy changes that affect your health care. It will be included in the your member newsletter or special mailings.

OTHER SERVICES

If you need medical advice or think you may need medical attention after normal clinic hours, or on weekends or holidays, you can call the Plan's Medical Advice Service and speak with the Plan physician or nurse on call. They will tell you how to take care of your medical problem at home or send you to the emergency room. The after-hours telephone number is **1 (800) 832-MEDI (1-800-832-6334).**

Advisory Committee

You are encouraged to become involved in the Community Health Plan Advisory Committee. Committee members work with Plan administrators and other Plan staff to assure the smooth operation of the Plan and to assure that Members receive the best possible care. The committee meets periodically during the year at various locations throughout Los Angeles County. For more information about participation on this committee, call the Plan's Member Services Department at 1 (800) 475-5550.

GLOSSARY

This glossary may be used to help you understand words and terms used in this Member Handbook. Please call **Community Health Plan** if you have any questions about the words listed here or a word you cannot find.

Acute is a term used for a serious and sudden condition that lasts a short time. Not *chronic*. Examples include a heart attack, pneumonia, or appendicitis.

Appropriately qualified health care professional(s) is a professional who is licensed to practice medicine. The doctor also has the training and expertise to treat the person's specific medical condition. When requesting a second opinion or standing referral the *member* will be referred to this doctor (*PCP* or specialist).

Authorize/Authorization is when a health plan approves treatment for covered *health care services*. *Members* must pay for all non-approved treatment.

Benefits are the *health care services*, supplies, drugs, and equipment that are *medically necessary* and covered by *Medi-Cal*.

Chronic is a term used for a condition that is long-term and on-going. Not *acute*. Examples include diabetes, asthma, allergies, and hypertension.

Clinical Trial is a research study with cancer patients, to find out if a new cancer treatment or drug is safe and works with the type of cancer that you have.

Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Curative is having the ability to cure or heal.

Diagnostic/Diagnosis is when a doctor identifies a condition, illness or disease.

Disability/Disabled/Disabling is a physical or mental problem that totally or seriously limits one or more major life activity.

Disenroll(ment)/Enroll(ment) is when a *member* leaves/joins a health plan.

Eligible/Eligibility means that a person meets certain requirements to receive, In-Home Support Services *benefits* from programs such as *Medi-Cal*, California Children Services (CCS), and Child Health Disability Program (CHDP).

Emergency Care includes medical screening, examination, and evaluation by a physician, or, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and if it does, the care, treatment, and surgery by a physician that is necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

Emergency Medical Condition is a medical condition manifested by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health or unborn child in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. This includes psychiatric disturbances and symptoms of substance abuse.

Emergency Services is the twenty-four hour emergency care that includes medical screening, examination, evaluation and treatment for an emergency medical condition or active labor. Emergency services also include care for an emergency psychiatric condition.

Experimental or investigational in nature is new medical treatment that is still being tested, but has not been proven to treat a condition.

Family planning services help people learn about and plan the number and spacing of children they want, through the use of birth control.

Grievance/Complaint is the process used when a *member* is not happy with his/her health care. *Grievances* are about services of care received or not received.

Health care services include some of the following:

- Doctor services (includes one-on-one visits with a doctor and referrals)
- Emergency services (includes ambulance and out-of-area coverage)
- Home health services
- *Hospital inpatient* and *outpatient* services
- Laboratory services
- *Pharmacy* services
- Preventive health services

- Radiology services

Hospice is the care and services provided in a home or facility to relieve pain and provide support to people who have received a *diagnosis* for a terminal illness.

Hospital provides *inpatient* and *outpatient* care from doctors or nurses.

Incarceration is when a person is placed in jail, prison or a mental institution for a long time.

Infertility is when a person is not able to conceive and produce children after having unprotected sex on a regular basis for more than 12 months.

Inpatient is when a person is admitted to (stays overnight in) a *hospital* or other health care facility.

Involuntary/Involuntarily is when something is done without choice.

Liable/Liability is the responsibility of a party or person according to law.

Medi-Cal is a state and federal health coverage program for low-income families.

Medical group is a group of *PCPs*, specialists, and other health care *providers* that work together.

Medically necessary/Medical necessity are those services provided to treat an illness or injury according to established and accepted medical practice standards.

Subscriber/Member is a person who has joined a health plan.

Member Services Department is the health plan's department that helps *members* with questions and concerns.

Mental health is the *diagnosis* or treatment of a mental or emotional illness.

Network is a team of health care *providers* contracted with a health plan to provide services. The health care *providers* may be contracted directly with the health plan or through a *medical group*.

Occupational therapy is used to improve and maintain a patient's daily living skills, because of a disability.

Orthotic is a device used to support, align, correct, or improve the function of movable body parts.

Outpatient is the medical treatment in a *hospital* or clinic without an overnight stay.

PASC – SEIU Homecare Worker Health Care Plan refers to the agreement between the Personal Assistance Services Council (PASC) and Service Employees International Union (SEIU) to provide eligible and enrolled Homecare Workers with health care benefits described in this handbook.

Pharmacy is a place to get prescribed drugs.

Physical therapy uses exercise to improve and maintain a patient's ability to function after an illness or injury.

Physician is a doctor.

Prescription is a written order given by a licensed *provider* for drugs and equipment.

Primary care physician (PCP) is a personal doctor. The *PCP* takes care of health care needs and works with *members* to keep them healthy. The *PCP* will also make specialty referrals when *medically necessary*.

Prosthesis is an artificial device used to replace a missing part of the body.

Providers are contracted with a health plan to provide covered *health care services*. Examples include:

- Doctors
- *Hospitals*
- *Skilled nursing facilities*
- Home health agencies
- *Pharmacies*
- Laboratories
- X-ray facilities
- Durable medical equipment suppliers

Provider directory is a list of *providers* contracted with a health plan for covered *health care services*. The list includes *PCPs*, h*ospitals, skilled nursing facilities,* urgent care, *pharmacies*, and vision care *providers.*

Skilled nursing facility is a facility licensed to provide medical services for non-*acute* conditions.

Speech therapy is used to treat speech problems.

IMPORTANT PHONE NUMBERS

Disability Services	
Americans Disabilities Act Coordinator	(916) 324-4695
Hearing Impaired/California Relay Service (TTY)	1-800-735-2929
Children Services	
California Children Services (CCS)	1-800-288-4584
Child Health and Disability Prevention (CHDP)	(323) 890-7941
California State Services	
State Department of Health Services (SDHS)	(916) 445-4171
SDHS Ombudsman Office	1-888-452-8609
Department of Social Services	1-800-952-5253
Department of Managed Health Care (DMHC)	1-888-466-2219
	(1-888-HMO-2219)
Supplemental Social Income (SSI)	1-800-772-1213
PASC–SEIU	1-877-325-4644
Los Angeles County Services	
Department of Public and Social Services (DPSS)	1-888-678-4477
Los Angeles County Department of Health Services	(213) 250-8055
Los Angeles County Department of Mental Health	1-800-854-7771
Women, Infant and Children (WIC) Program	1-888-942-2229
	1-888-WIC-Baby

Community Health Plan
1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit #4
Alhambra, CA 91803-1323
1 (800) 475-5550
1 (626) 299-7258 or 7259

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